Approximately half the doctors of medicine reporting for both 1929 and 1933 earned less than $6,000 in 1929, while three-fourths earned less than $6,000 in 1933. Twenty-five per cent earned over $9,000 in 1929 and only 10 per cent in 1933.*

In 1933 one-half of the osteopaths had incomes of less than $2,000. Eighty-six per cent of them earned less than $4,000.

Five per cent of the doctors of osteopathy earned over $10,000 in 1929. None were in this income class in 1933. Fifty-one per cent of the osteopaths in 1929, and 85 per cent in 1933, earned less than $4,000.

Dentists appear to have earned less than doctors of medicine but more than osteopaths, in both 1929 and 1933.

In 1933, 34 per cent of the dentists earned less than $2,000, 61 per cent earned less than $3,000, and 78 per cent earned less than $4,000.

Only 13 per cent of the dentists reporting incomes for both 1929 and 1933 earned less than $2,000 in 1929; but in 1933, the proportion was 30 per cent. Forty-four per cent earned less than $4,000 in 1929, as compared with 76 per cent in 1933.

The depression seems to have affected the incomes of dentists and osteopaths more than those of doctors of medicine.

Eighty-one per cent of the 4,882 families upon which information has been tabulated reported annual incomes in 1933 of less than $2,000. Of these 26 per cent had incomes ranging from $2,000 to $1,200, and 55 per cent had incomes of less than $1,200.

Out of the 19 per cent of families found to have incomes of over $2,000 in 1933, 11 per cent had incomes ranging from $2,000 to $3,000, 5 per cent had from $3,000 to $5,000, and nearly 3 per cent had incomes of $5,000 and over.

Of all persons in the income class under $1,200, 17.3 per cent required medical attention in contrast to the 8.6 per cent of persons in the income class of $5,000 and over.

No significant differences in the need for medical care appear among the income classes between $1,200 and $5,000. The proportion of persons needing medical attention who received a diagnosis is smallest in the low income classes and greatest in the high income classes.

Twelve and three-tenths per cent of all persons in the income class under $1,200 were reported as requiring dental attention against 4.4 per cent in the class of $5,000 and over.

The proportion of persons needing dental attention who received a diagnosis varies with income, and relatively more sharply so than those reporting a need for medical attention who received a diagnosis.

Only 21.2 per cent of the income class under $1,200 needing dental attention were receiving it, while 60.3 per cent of those in the $3,000 to $5,000 class who reported the need for treatment were receiving it.

Twenty-five and seven-tenths per cent of all families studied reported no medical and dental charges had been incurred within the period September 1, 1933, to September 1, 1934. This does not necessarily mean, however, that they were receiving no medical care, for some may have received free clinical attention or free services from members of the professions.

The proportion of families reporting no charges incurred during a one-year period varies from 33.4 per cent in the group under $1,200, to 10.4 per cent in the group of $5,000 and over.

In each income class there are both large groups of families experiencing high charges and large groups experiencing low charges.

Of the families receiving less than $1,200 in 1933, 15 per cent reported that charges ranged between $20 and $40; 8 per cent reported charges of $100 to $200; 3.8 per cent or 103 families reported charges of between $200 and $500; twenty-three families reported charges between $500 and $1,000, and nine families reported charges of over $1,000.

Medical charges amounted to a proportion varying from half to all of the reported income of thirty-two of the families incurring charges of over $500. Of the families reporting incomes in 1933 ranging from $1,200 to $2,000, 15 per cent reported medical and dental charges from $100 to $200, while another 8 per cent reported charges of from $200 to $500.

In the income group between $2,000 and $3,000, 19 per cent of the families incurred charges between $100 and $200, and 14 per cent incurred charges between $200 and $500.

A great variety of health insurance schemes exist in various parts of the world. These include voluntary, semi-voluntary and obligatory plans.

The general tendency in recent years has been towards the extension of obligatory health insurance schemes in areas where they already existed, and the adoption of obligatory schemes in areas where previously only voluntary or semi-voluntary schemes had existed. This tendency has been slightly checked in some areas by the financial difficulties associated with the present economic depression.

The survey reveals defects in the existing organization of medical and dental services in California. A study of different systems of health insurance reveals the existence of defects in all of them.

Perfection is unattainable. The merits and defects of existing arrangements have to be compared carefully with the merits and defects of alternative arrangements.

* Editor's Note.—Income figures given are net. The Final Report, based on a larger number of replies, may show variations from figures here printed.

PSYCHOTHERAPY*

By GEORGE S. JOHNSON, M. D.
San Francisco

DISCUSSION *by H. Douglas Eaton, Los Angeles; Clifford W. Mack, M. D., Livermore; Thomas G. Inman, M. D., San Francisco.*

IT is frequently asserted that psychotherapy is the oldest form of medical treatment. The inference might be drawn therefrom that in such an old and well-established practice, a review of its various techniques at the present time might be superfluous. However, there has arisen a situation in the general field of medicine that makes a consideration of psychotherapy peculiarly opportune.

THE SCIENTIFIC METHOD OF APPROACH IN MEDICINE

With the advent of the scientific method, and with its application to the field of medicine, there has developed a point of view that emphasizes, almost to the exclusion of others, the objective attitude toward the problems encountered. The essential character of science is not in the nature of the facts with which it deals, but in the method of attack which it employs. This method consists in the well known formula of, first, the observation of phenomena; second, the orderly arrangement and classification of the facts which have been observed; and, third, the finding of laws which will serve to explain those facts, and enable

* From the Department of Neuropsychiatry, University of Stanford School of Medicine.

Read before the Neuropsychiatry Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

us to predict and control the occurrence of future phenomena of the same order.

This method as applied to medicine has radically altered the entire discipline. The study of physiology has developed from a relatively simple investigation of the functions of the living organism into an elaborate search for the ultimate in living processes as expressed in the function of detachable parts. This has led to the erection of bigger and better laboratories, in which may be studied the finer details by physical, physicochemical, and biochemical means. Pathology has become concerned not only with the microscopical study of diseased cells, but it goes further into the ultra-microscopic interpretation of intracellular relationships. Bacteriology is no longer content to identify certain organisms, but must identify the subtypes and their variations. The pursuit of these and similar studies has had the tendency to emphasize the importance of the various phenomena to the exclusion of a consideration of the patient. While these studies have contributed immeasurably to the understanding of disease and disease processes, they have not added much to our understanding of the total patient. We have attained a place in the practice of medicine where, despite the possession of more exact methods of diagnosis and more complete knowledge of the nature of disease than ever before, we find physicians asserting that they are unable to treat from 40 to 50 per cent of their patients because they are "psychoneurotics," or admitting that, in their treatment, they are not giving the patient what he thinks he is getting or what he is paying for.

PSYCHIATRY'S CONTRIBUTION

If this be true—and statements made by professors of medicine throughout the country in a recent survey indicate that it is true—what has psychiatry to contribute at the present time for the relief of this situation? In the first place, it should contribute a point of view. Sound psychotherapy presupposes a knowledge of what constitutes normal behavior. As indicated by the prevailing trends in psychiatric education, this knowledge is embraced in the subject-matter designated by various names, but most commonly as psychobiology, a term introduced by Adolf Meyer. "Psychobiology," says Doctor Meyer,[1] "starts not from a 'mind' and a 'body,' but from the fact that we deal with persons as biologically organized units and groups, behaving in more or less definable situations. It studies chiefly others and ourselves, very much as we study others. It occupies itself with a 'body in action,' as far as we are able to denote behavior and function of that entity best described by the terms 'he' or 'she.' We are aware of a contrast between the activity of detached or detachable organs, such as the heart or the stomach or the brain, and the activity of these same parts when functioning as part of the 'he' or 'she,' or 'you' or 'I,' that is, units with subject organization and personality function. It is behavior, overt and internal, or implicit, as far as the organisms or person works as the 'he' or 'she' that concerns us. What we study as behavior naturally goes far beyond what we can read off from the dead body; we have to deal with the live organism in action, as behavior or ergasia in the process of life situations or life developments. There need be neither a neurological dilemma nor a philosophical one. There is a natural place for a psychobiology treating all the facts constituting man's behavior as a person—without a separation of mind and body, but as a biologically integrated organism in his natural attitude reaction or action, the material of a person's life record. It cultivates the habit of singling out what plays a vital rôle, in terms of specific experiments of nature, the conditions under which it occurs, the factors that enter into it when working, their results and their modifiability; in other words, a genetic-dynamic distributive analysis and synthesis."

PSYCHOPATHOLOGY

Such a concept of behavior furnishes a sound foundation upon which to build an understanding of the deviations of behavior which are found in the various categories of mental disease. This understanding is considered under the general heading of "psychopathology." This "science," which attempts to explain the problems of mental disorder by psychological principles and laws, has had a remarkable advancement through the work of various schools. Developing upon the background provided by Mesmer with his magnetizers, Braid with his hypnotisms, Charcot with his suggestion and hypnosis, Dubois with his persuasion, and followed by Freud and the psycho-analytic school, there has arisen a concept of mental disease and the underlying mechanisms that has altered all subsequent procedures. Many controversial points have arisen and many are still unsettled. While there has not yet developed an exact science in this field, much has been done that is serviceable in the field of psychotherapy.

Psychotherapy may be broadly defined as an effort to influence in the right direction the attitude of the patient—to influence his attitude toward himself, toward his mental and physical processes, and toward his environment. It is an effort to teach him to understand himself, his illness, and the cause or causes of his illness, whether this cause or these causes lie in his body, in his environment, or in the superficial or deeper layers of his mental life. The method or methods by which this is undertaken vary considerably. As expressed by Thom,[2] the nature of the therapy may be conditioned by (1) the personality make-up of the patient; (2) the nature of the symptoms; (3) conditions under which the symptoms are acquired; (4) the purpose they solve; (5) whether the precipitating causes continue to operate; and (6) the method in which the therapist has the most confidence.

PROCEDURE IN THE TREATMENT OF PSYCHONEUROSES

A method of procedure in the treatment of the psychoneuroses as advocated by Strecker and Ebaugh[3] may be stated as follows:

1. *Establishment of Rapport Between the Physician and Patient.* — The methods followed in

establishing that feeling of respect and confidence in the physician, which must prevail if the patient is to proceed successfully in his treatment, vary greatly. Shiny instruments and long, ambiguous words have played their respective parts. An effective method, however, and one that observes the dictates of sound medicine, is a careful program of investigation instituted at the first interview. A complete history should be a history of the patient as well as of his symptoms. A careful physical examination should follow, with recourse to those instruments of precision such as the x-ray and electrocardiograph which are specifically indicated, to complete your investigation and not to impress the patient. The doubt of the patient, who has been too exhaustively examined, is equaled only by the doubt of the skilled technician who knows the limitations of his instrument; and it bears no relationship to the confidence of the physician who blindly orders another x-ray, or basal metabolism, or blood chemistry, hoping thereby to convince the patient of the absence of a proper foundation for his symptoms. A mental examination should include not only the evaluation of his intellectual capacity, but also a consideration of his emotional responses.

2. *Aeration or Ventilation.*—This may be carried out by means of direct interviews, by means of discovering and probing for such material from outside sources, by hypnosis, or by any other method. The important thing is that the patient is given an opportunity to discharge and bring out in the open all of those experiences which have been causing him serious concern, either consciously or unconsciously.

3. *Desensitization.* — This is the procedure wherein the patient is required to face frankly the traumatic and unpleasant experiences of his past. It is brought about, in the first place, by causing the patient to discuss, at frequently repeated intervals, the material of conflict elicited. These interviews are repeated until the patient can review these experiences without excessive emotional concern. Normal emotional response is to be expected, however, and it is not desirable nor necessary to expect a complete loss of emotivity in connection with the events that should normally cause concern. It is the excessive concern that is pathologic and requires to be relieved.

The term "desensitization" is also applied to the procedure followed in relieving fear or other manifestations of symptoms in definite situations. The patient is required to face the situation repeatedly until he no longer manifests the symptoms in that situation, or until he is able to tolerate or ignore the symptoms if they do occur. It is necessary, of course, to encourage and reassure these patients repeatedly while this procedure is being carried out.

4. *Reëducation.*—This accompanies the foregoing procedures. It is essentially the development of clear insight on the part of the patient into the mechanism of the illness, the establishment of new habits of response (as in desensitization), and the formulation by him of an adequate industrial, social, recreational, and otherwise useful program of activity to insure future stabilization.

5. *Desensitization of the Family.*—In addition to the foregoing, it is often advisable to desensitize the patient's family to his illness, and to reëducate them into new habits of response toward the patient.

6. *Remedy of Physical Factors.*—All contributing physical factors are corrected as far as possible. Measures for their correction are instituted at the earliest possible interview, and are utilized as psychotherapeutic aids.

The procedures outlined, to be carried out intelligently, require that every individual case be formulated in terms of its causative factors in such a way that the factors that can be modified are emphasized, and become the center of attention. Factors which cannot be altered are recognized as such, and the patient is trained to tolerate them.

The development of child guidance has introduced many new procedures, valuable alike to the psychiatrist and to the pediatrician. It has emphasized beyond anything else the importance of case studies in personality and psychiatric problems. It has effectively liberalized the social point of view of psychiatry.

A matter of great importance in the consideration of psychotherapy, as it concerns the frankly psychotic patient, is that it begins with the first professional contact with him. Highly trained personnel are greatly handicapped, and the benefit of elaborate equipment is almost nullified, if the patient encounters only difficulty and disgrace in his efforts to secure such services. As long as a legal and disciplinary attitude prevails in the procedures through which a patient is admitted to a hospital for the treatment of a mental disorder, therapy directed toward that patient's recovery will be seriously handicapped. It is of the greatest importance that the work of revising the laws governing the admission of patients into the state hospitals be carried on as the first step in a program for adequate psychotherapy in those institutions.[4]

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DISCUSSION

H. Douglas Eaton, M. D. (1136 West Sixth Street, Los Angeles). — The need for a scientific type of psychotherapy in this country, and especially in our own state of California, is evidenced by the number of cultists who surround us. Christian Science, Unity, New Thought—all represent narrow attempts to fill a definite need, and their existence is a challenge to the medical profession. As Doctor Johnson has pointed out, the percentage of functional disorders, a group peculiarly susceptible to psychotherapy and a group

we are all called upon to treat, represents, in a conservative estimate, 50 or 60 per cent of all our patients. In treating these cases, many of us either entirely ignore the value of psychotherapy or utilize it blindly and unintelligently.

Doctor Johnson is to be congratulated on his clear exposition of psychotherapeutic aims and methods. A careful study of Doctor Johnson's paper will be of value to us all, wherever our special interest in medicine may be, and I find myself even more thoroughly in accord with Doctor Johnson's views after a study of his paper than I was when I heard him read it.

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CLIFFORD W. MACK, M. D. (Livermore Sanitarium, Livermore).—The treatment of mental and functional nervous diseases was for a long time in medical practice confined entirely to the somatic approach. Doctor Johnson has given us a very sane and clear-cut discussion of the treatment of these illnesses by psychotherapy. In this analysis he does not neglect the physical side, but at the same time he shows that the mental symptoms should be attacked by study of the psychic mechanism. We have long since passed the time when the mental and nervous patient is treated solely by correcting the physical abnormalities by surgery, or only on the basis of some reflex disturbance.

One of the most difficult tasks is to convince the family and friends that the essential features of the illness are in the realm of the patient's psychic or emotional life, and that they are not caused by some bodily disease. The patient even may grasp this idea much more readily than members of the family. I fully agree with Doctor Johnson as to the necessity of the reëducation of the family as well as the patient. I have often seen the work of many weeks destroyed in a short interview with the patient by some member of the family who wished to practice his or her own type of psychotherapy, or present some new theory about the illness.

There is only one point which I wish to add, and that is to call attention to the importance of suggestion as well as psycho-analysis. It may properly be argued that suggestion is only symptomatic treatment, but in no field of medicine can we neglect the value and usefulness of something that will alleviate or nullify troublesome symptoms. Doctor Johnson's exposition of the subject is of very valuable assistance to all of us engaged in treatment of nervous and mental patients.

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THOMAS G. INMAN, M. D. (2000 Van Ness Avenue, San Francisco).—This article by Doctor Johnson may be taken somewhat in the nature of a declaration of principles signalizing, as it does, his entrance into the field of neuropsychiatry in California. And these principles prove to be quite sound, when gauged by modern conceptions of mental disorders.

As he has intimated, rule-o'-thumb methods are insufficient in themselves, and no hard-and-fast rule can be laid down which will be applicable to each individual patient. Yet, method is necessary, and every physician doing this kind of work must have a definite plan which he uses in his search for the causes of the disorder at hand.

Doctor Johnson has outlined very closely the aims of such an investigation, as well as the direction which treatment must take. His broad views inspire confidence, and lead to the hope that his work here may bring about a more complete understanding of this, as yet, obscure subject.

The closing comments upon the method of commitment of the insane in California voices the opinion of everyone interested solely in the personal welfare of these unfortunate patients. The primitive methods now in force seriously interfere with the early institution of treatment, and undoubtedly do much to prolong the period of hospitalization.

COMPULSORY HEALTH INSURANCE*†

By FREDERICK L. HOFFMAN, LL.D.
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XI

SOCIALIZED medicine is reviewed in the *Literary Digest* of December 29, 1934, in its annual review of progress made during the year in science and engineering. After an enumeration of outstanding discussions in the field of medicine, it is said:

"Socialized medicine," or the placing of physicians on government payrolls, and "health insurance," or provisions of medical treatment for the payment of small, regular, voluntary fees, were leading plans proposed. Both were bitterly opposed by officials of the American Medical Association, but health insurance was advocated by increasing numbers of physicians, dentists, nurses, and social agencies; by city, county, and state medical societies, and by the American Hospital Association, and the American College of Surgeons.

In this statement, however, the compulsory feature of the system is not emphasized, and that goes to the root of a very disturbing situation. It is seriously to be questioned whether the medical profession at large is more than vaguely conscious of what is actually implied in the various proposals. And unless it is aroused out of its apathy it may realize when it is too late that its professional independence has been sacrificed for a mediocre amount of economic security.

MAJOR PROPONENTS OF COMPULSORY HEALTH INSURANCE

The propaganda for compulsory health insurance is largely in the hands of and within the control of nonmedical men supported, in part if not wholly, by some of the great foundations more or less international in character and purpose. The outpourings of briefs and reports reveal no thorough grasp of the proper medical considerations, but rather the academic viewpoint of the green table and easy chair philosophy. It is supported by pleas for the poor or underpaid workers whose medical needs are said to be badly neglected. It insists that the medical care of the lower-wage group should be raised to the very best that can be provided, although the richest nation of the earth could not meet the expenses which would call into being a huge administrative apparatus largely of a nonmedical nature. The British health insurance committee makes the bold assertion that this is an "Act to provide against loss of health," but no agency has come into existence in the twenty-one years of its life to provide in an effective manner against the onset of disease. It may be safely asserted that the health of the British

* One of a series of articles on compulsory sickness insurance written for CALIFORNIA AND WESTERN MEDICINE by the well-known consulting statistician, Frederick L. Hoffman, LL.D. Articles in this series were printed in issues as follows: I, in April, 1934, page 245; II, in May, page 361; III, in June, page 411; IV, in July, page 33; V, in August, page 114; VI, in September, page 177; VII, in October, page 262; VIII, in November, page 323; IX, in December, page 398; X, in February, 1935, page 108.

† Note—As stated in the editorial masthead, "Authors are responsible for all statements, conclusions and methods of presenting their subjects" in CALIFORNIA AND WESTERN MEDICINE. See also editorial comment in this issue, page 190.